Restricted

NAVY DEPARTMENT

BUMED NEWS LETTER

a digest of timely information

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Combat Fatigue: The attention of medical officers is called to the importance of the proper use of diagnostic terms, particularly with respect to psychiatric terminology. Medical records are permanent official documents which have medico-legal importance. It is especially important that diagnoses of the various psychoneuroses be made only when the symptoms are readily demonstrable; such diagnoses can never be made by exclusion.

The diagnoses "Combat Fatigue" and "Operational Fatigue" were included in Navy nomenclature in order to designate certain psychosomatic

conditions and to prevent the term, "psychoneurosis", from being placed upon a man's record until such time as the presence of a neurosis is confirmed by careful study in a hospital. The deficiencies of the terms are recognized, but these terms are for intra-mural use; no one is ever discharged from the Navy with a diagnosis of combat or operational fatigue. The term implies that the congeries of symptoms which result from combat or long-continued operations under difficult conditions will clear up when the precipitating factors are removed and the patient is treated by rest and sedation.

In order to prevent these diagnoses from becoming convenient "scrap baskets" into which various syndromes are pushed, the following diagnostic criteria for combat and operational fatigue diagnoses should be satisfied:

1. The patient should have demonstrated a stable personality prior to the appearance of symptoms, i.e., no evidence of gross maladjustment in childhood or adolescence, and should have a previous service record indicating his competence and stability.

2. He should have been exposed to combat or operational experience of sufficient intensity and duration to be capable of producing the symptoms.

3. The illness should be one from which the patient is expected to recover.

4. He should manifest objective evidence of subjective anxiety; i.e., physiological manifestations. The symptoms evidenced by these patients are fairly uniform. They are:

a. Heightened irritability (startle response, night terrors, vigil state, etc.).
b. Autonomic nervous system symptoms (tachycardia, G. I. disturbances, etc.).
c. Fatigue - a diminished capacity for work.
d. Personality changes in the direction of anxiety, panic, apathy, confusion, depression, etc.

These patients should nearly all recover following rest, sedation, and short-term intense re-educative psychotherapy. (W.F.K.)

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Therapy of Malaria with Arsenicals: The organic arsenicals, arsphenamine, neo-arsphenamine and mapharsen, as well as various preparations of bismuth, have been employed frequently in the treatment of malaria. While these compounds have some favorable effect on the acute clinical attack of vivax malaria, they are less efficient therapeutically in this condition than atabrine or quinine. They do not limit the frequency or severity of relapses in vivax malaria. They cannot be relied on to control clinical attacks due to

falciparum infections. In general, treatment of malaria with arsenicals entails some threat to life, whereas treatment with accepted antimalarial drugs does not. Since the arsenicals present certain serious disadvantages without compensatory advantage, their use cannot be recommended when atabrine or quinine is available. (O.J.B.)

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The Use on Burns of Ointments Containing Sulfonamides: Of foremost importance in the initial treatment of patients who have been burned are combating shock, protecting the burned surface from further contamination by bacteria and applying pressure dressings to minimize, as far as is possible, further loss of fluid from the burned area. It is usually recommended that a grease be applied to the burned area. Such a substance by limiting coagulation permits an outward flow of body fluids of undiminished antibody content and also facilitates subsequent removal of the dressings. The Bureau has been informed by the Committee on Infected Wounds and Burns of the National Research Council that petrolatum is the grease to be preferred.

The badly burned patient is threatened with the development of septic complications, and there is good evidence to justify the systemic use of sulfonamides in an attempt to reduce their frequency.

There is no convincing evidence that the incorporation of the sulfonamides in ointments for application locally to burned areas is of value. Controlled studies have not shown that the topical use of sulfonamides reduces the incidence of infection. One reason why this would be expected is that the duration of local action of the sulfonamides is very short, while it is considered good surgical practice to change the dressings as infrequently as is practicable. Furthermore, the absorption of the drug from extensive areas of burn may result in the production of undesirably high plasma levels of the drug, especially where local and parenteral chemotherapy are combined.

In view of their wide use in the treatment of burns in the present war, ointments containing sulfonamides have been considered by some as responsible for the striking reduction in mortality and in incidence of infection that has been accomplished with respect to these patients; in fact, healing is accomplished more quickly. However, equally good results have been achieved where petrolatum alone has been used. Most of the reduction in mortality may be attributed to the effective treatment of shock with blood, plasma, and sodium salts, to the prevention of further contamination by the immediate application of a sterile dressing and to the reduction of loss of fluid from the burned area by the application of pressure.

It is the desire of the Bureau not to place any restriction on the surgeon who believes that a sulfonamide locally applied will aid in the treatment of individual patients with burns, but rather to point out that reliance should not

be placed in this form of therapy, and that where large areas are burned, its use, because of uncontrollable absorption of the drug, is not entirely without danger.

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Phlebotomus (Pappataci or Sandfly) Fever: In the July 1 and July 8, 1944, numbers of the Journal of the American Medical Association there appears a paper by Sabin, Philip and Paul on Phlebotomus Fever. The investigations of the disease made by these workers were carried out under the direction of the Commission of Neurotropic Virus Diseases, Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army, Preventive Medicine Division, Office of the Surgeon General, United States Army.

The following information relating to phlebotomus fever has been taken from this paper:

Phlebotomus fever is a disease of military importance because it occurs in many parts of the world where troops are stationed and because it can incapacitate large numbers of persons at a time for seven to fourteen days.

This disease has a widespread geographical distribution which includes particularly those parts of Europe, Africa and Asia which lie in the belt between 20 and 45 degrees north latitude. It persists chiefly in the lowlands of those subtropical and tropical countries where there are long periods of hot, dry weather, and has a seasonal incidence depending on prevailing temperatures and the periods when the rainy season ceases and reappears.

The course of the disease is characterized in most instances by fever of two, three or four days' duration, severe frontal headache, pain in the eyes with tenderness to touch and on movement, photophobia and pain in the back and extremities.

While there is no specific laboratory test diagnostic of the disease, there are changes in the leukocyte count which are characteristic. In order to demonstrate them, repeated Schilling differential counts must be made.

The disease may or may not be associated with a true leukopenia, but a pronounced relative and absolute reduction in the number of segmented neutrophils associated with a simultaneous definite relative and absolute increase in immature neutrophils (chiefly the staff cells) is a constant phenomenon.

The blood picture in dengue on the other hand is characterized by a leukopenia with relative increase in the mononuclear elements but without a "shift to the left" in the neutrophils.

When leukocyte counts are done daily during the febrile and postfebrile periods of phlebotomus fever, a reduction to below 5,000 cells per cubic millimeter from a higher normal level may be expected in approximately 90 per cent of the cases.

A leukopenia is rarely encountered on the first day of the fever but is more often seen later, especially at the end of the fever and during the first two days of the postfebrile period.

The characteristic findings on the first day of the fever are a total count within normal limits, a relative and absolute decrease in the lymphocytes, and a relative and sometimes absolute increase in neutrophils which is due to an increase in immature cells. The total number of segmented neutrophils is usually not decreased at this time.

During the second or third days of the fever the number of lymphocytes begins to return to normal and for a few days thereafter may constitute 40 to 65 per cent of the total. At the same time the number of segmented neutrophils begins to drop and the immature cells increase to a point at which they usually outnumber the segmented cells.

Unless differentiation is made between the segmented and the immature cells (or filament and nonfilament cells) the significant changes in the neutrophils may be missed, since the total percentage of these cells may never be less than 50 to 60. A reduction in neutrophils to as low as 30 per cent, even when the total leukocyte count is less than 5,000, is not compatible with a diagnosis of phlebotomus fever unless the immature cells make up a large proportion of all the neutrophils.

The changing relationships between the different types of cells at various stages of the disease are more important for diagnosis than any single observation. The normal picture usually returns five to eight days after defervescence. The dromedary type of curve for the immature cells is commonly found when daily counts are done. There appears to be a point, during the febrile or postfebrile periods, at which both the immature and the segmented neutrophils are decidedly depressed.

No abnormal findings have been encountered upon examination of the cerebrospinal fluid. The Hanger cephalin flocculation test is negative. The erythrocyte sedimentation rate is either normal or slightly increased. Attempts to develop a specific precipitin reaction, complement-fixation reaction and skin test were unsuccessful.

In the absence of a specific test for the individual case, the diagnosis of phlebotomus fever must be made on clinical and epidemiologic grounds. The occurrence in a number of individuals of this clinical syndrome together with

changes in the leukocytes of the type described, during the summer or autumn months in a country known to harbor phlebotomus flies, may reasonably warrant the diagnosis of an outbreak of phlebotomus fever. Dengue, which perhaps more closely simulates phlebotomus fever than does any other disease, usually has to be considered in the differential diagnosis when an epidemic occurs in a locality in which both fevers may be endemic. The following differences observed in the experimentally reproduced diseases may be useful in the differential diagnosis of epidemics of the two fevers:

1. In phlebotomus fever more than 80 per cent of the cases are made up of two, three and four-day fevers, while in dengue approximately 80 per cent of the cases exhibit five, six or seven-day fevers.

2. Lymphadenopathy is common in dengue, uncommon or absent in phlebotomus fever.

3. While certain cases of dengue may not exhibit a rash, it is nevertheless common in dengue and exceptional in phlebotomus fever. The diagnosis of dengue in an epidemic in which rash is uncommon is open to question.

Sandfly fever is caused by a filterable virus which is present in the blood for at least 24 hours before and after the onset of fever but is no longer detectable 40 to 48 hours thereafter. The virus is of small size (probably in the same range of magnitude as that of yellow fever) and, while the authors have found it readily transmissible to human volunteers, it has not been found to be infectious for any of a large variety of animals which have been tested. The virus has been preserved for at least six months in the frozen or lyophilized state.

Phlebotomus papatasii is a yellowish, two-winged, hairy midge whose body is about 2 to 3 mm. long and somewhat less than 1 mm. thick. Only the female of the species bites and does so during the night and early hours of the morning. The body of the female appears distended and red for some hours after a blood meal, and black for several days thereafter. While the bite itself is usually painful, there is no reaction to it until and unless the person has developed an allergy to the secretions deposited during the bite. In persons not previously bitten by these insects there is neither pain nor local irritation after the initial stab. The bitten site may be marked by a pinpoint, reddish or hemorrhagic spot or may be inconspicuous. However, about one to two weeks later (without exposure to other bites during the period) inflamed papules usually appear at practically all the sites of the original bites. These papules are 2 to 3 mm. in diameter, raised about 0.5 mm., pink or red, and not infrequently vesicular. Their appearance is not necessarily associated with itching, although moderate to severe itching is usually present later. These lesions are prominent for four to five days and then slowly disappear. Once sensitization is established such papules appear earlier after subsequent bites, and

in certain hypersensitive persons there is an almost immediate urticarial reaction which may produce pronounced and extensive swelling of the eyelids or lips when these sites are bitten. Some persons, however, do not become sensitive.

These insects are most prevalent near the ground level, and only small numbers of them are encountered in upper stories of buildings. Their flight is characteristically in short, jerky hops along the walls and ceiling. They rarely bite people who are in motion or when there is a strong breeze. Because of their small size and their ability to penetrate small apertures, the ordinary screen and mosquito bar fail to keep them out. There is reason to believe that their range of flight is very short and that insects found in human habitations probably originate from breeding sites within a radius of about 50 yards; there is some question, however, as to whether there may be exceptions to this rule. Phlebotomus papatasii is known to breed in rubble, dugouts, cracks in the earth, walls and embankments, garden soil and other dark protected spots containing moist organic matter. The flies are not, however, aquatic like mosquitoes, and too much moisture drowns the larvae. It has been observed that material for a possible breeding place is too damp if it adheres to the fingers and does not fall off when it is gently rubbed between them. It is apparent, therefore, that neither the sands of the desert nor the excessively moist areas of the tropics can be expected to provide suitable breeding grounds. The disturbance of ground incident to the establishment of certain military installations, such as occurs in the excavation of tent floors, the building of parapets and the erection of new buildings, can provide good potential breeding grounds. In warm weather approximately four and one-half to six weeks are required for the eggs to develop into adults. The life of the adult is believed to be relatively short in hot weather. In the laboratory it is not over two to three weeks.

The authors recommend the following prophylactic measures:

Sleeping quarters should be on as high ground as practicable, on open, dry, sandy ground when feasible, and as far away from the native dwellings and domestic animals as possible. The more breeze there is in a given location the better.

Whenever possible the area occupied by sleeping quarters and that within a radius of 50 to 100 yards around it should be free of rubble, detritus, gardens, vegetation and needless earthen walls or banks. The ground surfaces in such an area should be leveled and rendered as impermeable as practicable by filling in and stamping down cracks in the earth or by tarring or cementing, especially in permanent installations. Whenever these measures are impracticable or impossible, it may be worth while to attempt to render the ground unsuitable for breeding by oiling with waste motor oil or crude oil or by application of creosote; sandbag walls and embankments should receive the same treatment.

Inside the sleeping quarters it is advisable (a) to eliminate cracks and crevices in the walls or, when that is not feasible, to spray them with an insecticide, (b) to reduce all fixtures to a minimum, (c) to keep beds, kits and clothing away from walls, where the insects usually seek protection during the daytime, (d) to use the pyrethrum bomb spray, (e) to utilize electric fans to best advantage whenever available and (f) to use sleeping nets of fine enough mesh (more than 45 to the inch) whenever they do not interfere with sleep.

Dimethyl phthalate and a pyrethrum-containing vanishing cream applied to the exposed skin surfaces were both found to be effective repellents for phlebotomus papatasii. (J.A.M.A., July 1 & 8, '44.)

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Transfusion during Operation: At a meeting of the Committee on Surgery of the National Research Council, May 9, 1944, Dr. Blalock (Johns Hopkins University School of Medicine) summarized as follows his views on the use of blood and blood derivatives or substitutes during operations:

"Experience has shown that shock in association with operations can usually be prevented by the administration of blood during the operative procedure. One should attempt to maintain the blood volume and blood pressure at the normal levels rather than to postpone the transfusion until after shock has developed. A great aid in this respect is the introduction of a needle into an accessible vein before the operation is begun. With the needle in place, one is less apt to procrastinate in the giving of fluids, which should be administered according to the severity and duration of the operative procedure and blood loss. Furthermore, in the case of severe hemorrhage, replacement therapy can be performed without the loss of valuable time."

This statement met with unanimous approval and gave rise to the following resolution:

"The Committee on Surgery recommends to the Surgeons General that the value of transfusions during major operative procedures be re-emphasized and that surgeons be urged to insist upon the introduction of a needle into an accessible vein (arm or ankle) prior to the beginning of the operative procedure."

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Experimental Sea Rescue: The following item is an excerpt from the Monthly Sanitary Report of a Destroyer, submitted by Lt. L. M. Roe (MC), USNR, and originally published in the Atlantic Fleet Medical News Letter of June 10, 1944:

"In experimental rescue, this ship has found the following method of raising exhausted or injured men aboard the rescuing ship to be of practical application:

"If a canvas covers the bottom of a Stoke's stretcher it is removed. Appropriate lines are secured to each end of the stretcher. The stretcher is then lowered over the side of the rescuing ship and allowed to sink about two feet beneath the surface of the water. A totally disabled or exhausted survivor can then be easily floated over the stretcher. The stretcher is then raised underneath the injured man who can quickly be adjusted in the stretcher and then hoisted aboard.

"It is believed that partially injured or weak survivors could float themselves over and into the stretcher in instances where they could not tie a line to themselves or climb a cargo net up the side of the ship."

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The Common Skin Diseases (III): Furunculosis:

Etiology: Staphylococcus Aureus.

Clinical Features: There is no need to describe a typical furuncle or "boil." When, however, the lesions become multiple and new ones continue to develop, the problem often becomes a difficult one from the therapeutic standpoint. In the tropics a previously mild folliculitis or acne will often develop into a widespread furunculosis.

Treatment: (A urinalysis and blood sugar determination are indicated to rule out diabetes).

Care of Individual Lesions: Surgical incision, if done, should be delayed until "pointing" is well established or general fluctuation is evident. Many writers hold the opinion that surgical interference is unnecessary.

Wet dressings using sodium chloride or magnesium sulfate, or moist heat, are useful. The application of the mercurial tinctures (Merthiolate, Metaphen, etc.) are often satisfactory as a local measure to prevent "seeding" into neighboring hair follicles.

X-ray therapy (100 to 200 r daily for two to three doses) will often abort early lesions.

General therapy: Staphylococcus toxoid may prove helpful in chronic cases. Autogenous vaccines are of doubtful value.

Price (J.A.M.A., Apr. 27, '44.) recently has advised the thorough cleansing of the entire area involved with 70 per cent alcohol (by weight - not volume). This procedure is best carried out when the latest lesions have stopped draining and new lesions have not yet appeared. Gauze is employed as a washcloth and the cleansing should be thorough, requiring 15 to 30 minutes. The author intimates that one such treatment will often prove sufficient to prevent the appearance of new furuncles. At Chelsea Naval Hospital the procedure has been carried out every second day for two or three treatments. Results have been distinctly encouraging. A more extended trial is justified.

A word of caution should be given in regard to furuncles involving the "dangerous triangle" (from the base of the nose to both corners of the mouth). Surgical interference here is fraught with danger. Any type of manipulative or drastic local treatment is absolutely contraindicated. Adequate systemic administration of a sulfonamide or penicillin, wet dressings and possibly X-ray therapy are the most useful procedures in handling such cases. Complete rest, including the use of a glass feeding tube, is advocated until all acute symptoms have subsided. The reason for the conservatism of the treatment in this type of case is the possibility of intracranial venous thrombosis and infection. Many writers consider all furuncles of the face as occurring in the "danger zone." (J.M.S.)

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Methyl Alcohol Poisoning: Among the unsolved problems of the entity known as methyl alcohol poisoning the actual toxic mechanism and the selective incidence of amblyopia have hitherto taken first place. It has long been known that methyl alcohol is a comparatively weak narcotic but a strong cumulative metabolic poison, and that it produces an acidosis; but the source and nature of the acidosis have never been completely explained. Nor has it been decided whether the amblyopia bears any direct relation to the acidosis, or why the toxic action should be selectively exerted upon either the optic nerve or the ganglion cells of the retina. Answers to some of these questions have now been provided by an investigation (Roe, O., Acta Med. Scand., '43, 113, 558.) of 16 cases of methyl alcohol poisoning, and suggestions for treatment are based on the knowledge obtained.

The symptoms in these cases undoubtedly resembled the clinical manifestations of acidosis - anorexia, nausea, vomiting, dyspnea, drowsiness, and coma - and their severity was commensurate with the fall in the alkali reserve which was 9 volumes per cent in a very acute case as compared with 33.8 in a case with only mild general disturbance. The degree of amblyopia also appeared to depend on the degree and duration of the acidosis. On the basis of these facts and the actual demonstration in two cases of an increase in the lactic acid concentration of the blood, an hypothesis of the true nature of the

acidosis is advanced which embodies some of the conflicting elements of the long controversy on formic acid versus formaldehyde as the specifically harmful decomposition product of methyl alcohol. It is suggested that the factor primarily responsible for the acidosis is formic acid, which enters into a complex compound with the iron of the respiratory enzyme, thus inhibiting oxidation and causing an increase of lactic acid. Correlation between the degree of acidosis and the severity of amblyopia is explained by the high consumption of oxygen by the retina (demonstrated by Warburg) and its consequently high susceptibility to defective oxygenation, this being followed by degenerative changes in the retinal cells. Since exposure to strong light increases the call on oxidation, this might be expected - as was indeed found to be the case - to increase the severity of the amblyopia. The secondary later deterioration of vision characteristic of methyl alcohol poisoning is attributed to subsequent atrophy of severely injured retinal structures.

A rather surprising feature of the course of the poisoning in some of the cases was the favorable action of ethyl alcohol. Those patients who had drunk large quantities of port, gin, or beer either before or after the methyl alcohol showed no permanent ill effects. This, it is suggested, is due to the capacity of ethyl alcohol to displace methyl alcohol from its intracellular attachments, thereby checking its oxidation to formic acid. The heroic recommendation that ethyl alcohol shall be drunk repeatedly during the first few days after the consumption of much methyl alcohol is therefore included in the treatment advised. Other measures include the rapid correction of acidosis by intravenous injection of isotonic (1.3 per cent) solution of sodium bicarbonate; liberal flushing with fluid; protection from exposure to light; and avoidance of all stimulants of metabolism, such as exercise, hot baths, and thyroid extract. (Editorial, Brit. M. J., May 13, '44.)

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Immunization Certificates Required for Travel Outside the United States: Failure to satisfy immunization requirements prior to embarkation has been a common cause of confusion and loss of valuable time among naval and civilian personnel traveling alone or in small groups under the cognizance of the United States Navy Department outside the United States.

In order to eliminate this confusion and interference with travel the Secretary of the Navy in a letter to All Ships and Stations, P2-3/P3-1(034), dated May 2, 1944, directed that all such naval and civilian personnel (a) must be properly immunized before embarkation for points outside the United States according to the schedule below and (b) must have in their possession prior to embarkation an immunization record certified by a naval medical officer (see sample of United States Navy Immunization Record on page 13).

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Check List* of Immunizations Required for Naval and Civilian Personnel Traveling Under the Cognizance of the United States Navy Department Outside the United States

	IMMUNIZATIONS						
	Small-pox Within the past year	Typhoid Within the past year	Tetanus Within the past year	Yellow Fever** Within the past 4 years	Typhus Within the past 6 months	Cholera Within the past 6 months	Plague Within the past 4 months
West Indies	+	+	+	+	-	-	-
Mexico and Guatemala	+	+	+	+	+	-	-
Venezuela, Colombia, Ecuador, Peru	+	+	+	+	+	-	#
Remainder of S. America	+	+	+	+	-	-	#
Africa and Madagascar	+**	+	+	+	+	-	#
Eire, Southern Europe, the Balkans, European U.S.S.R.	+	+	+	+	+	-	-
Asia Minor and the Middle East	+**	+	+	+	+	-	#
India and Eastern Asia	+**	+	+	+	+	+	#
Southeast Asia	+**	+	+	+	+	+	#
Philippines	+	+	+	+	-	+	-
Sumatra and Java	+	+	+	+	-	+	#
Celebes	+	+	+	+	-	+	#
Borneo and New Guinea	+	+	+	+	-	-	#
Japan and Formosa	+	+	+	+	-	+	-
Polynesia, Micronesia, Melanesia	+	+	+	+	-	-	-
Australia and New Zealand	+	+	+	+	-	-	-
All other areas	+	+	+	+	-	-	-

*This check list is not to be considered final; of necessity local requirements will have to be complied with.

+ Required.

Recommended for particularly exposed personnel, but not routinely required.

- Not required nor recommended.

** Immunization within the previous 6 months is required in these areas.

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U. S. NAVY IMMUNIZATION RECORD

Smith, Frank W. ..... PhM 2/c .....
(Name) (Rank/Rate)

Type	Date	Remarks	Signature
Cowpox	5- 4-44	Immune react.	F.C. Conway
Typhoid	5- 4-44	Booster	F.C. Conway
Tetanus	5-11-44	Booster	K.R. Coors
Yellow Fever	6- 8-43	Initial Imm.	P.S. Shore
Typhus	5-18-44	Initial Imm.	O.M. Furst
Typhus	5-25-44		O.M. Furst

Back

Type	Date	Remarks	Signature
Cholera	5-21-44	Initial Imm.	O.M. Furst
Cholera	5-28-44		O.M. Furst
Plague	6- 4-44	Initial Imm.	O.M. Furst
Plague	6-11-44		O.M. Furst

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On May 11, 1944, the Bureau of Naval Personnel, in accordance with the above requirements, issued a letter to All Ships and Stations, P16-4(A), directing that all commands authorized to issue travel orders necessitating departure from the continental United States include in those orders a provision requiring that prior to departure a certificate of immunization be secured.

Since the issuance of the above letters, repeated instances in which personnel have arrived at points of embarkation from the United States without immunization records in their possession have been noted. Failure to meet this requirement has apparently occurred most frequently among personnel seeking to return to duty outside the United States after leave in the United States. Since it is essential that in certain commands a large proportion of personnel hold themselves in readiness for travel outside the United States on short notice, it is suggested that in such commands (a) all personnel be provided with their individual Immunization Records on a card 2-1/4" by 3-3/4" (to match the U. S. Navy Identification Card); (b) that all personnel be instructed to safeguard their Immunization Records, to keep them current, and have them immediately available in case travel outside the United States requires their use. (D.F.S.)

Penicillin Supply: The position with regard to penicillin has now improved to the extent that a more satisfactory distribution can be accomplished. Overseas storehouses and hospitals are placed upon automatic supply of penicillin in such amounts as they request. Hospital ships are given an automatic supply when requested, with the understanding that these activities will serve as a source of supply for similar activities requiring this drug.

Penicillin is now available for issue from Naval Medical Supply Depot, Oakland, California, for activities in the 11th, 12th and 13th Naval Districts and for shipments from the west coast. A small amount has been placed in the Naval Supply Storehouse at San Diego for emergency issues in that area. At an early date it is proposed to provide a small amount of penicillin for emergency issues for all continental Medical Supply Storehouses. Routine issues to large activities are expected to be made from the Medical Supply Depot at Oakland and Brooklyn. The supply in Medical Supply Storehouses is intended to cover issues to ships and emergency requirements of nearby shore establishments in cases where time does not allow issue from Oakland or Brooklyn.

So far as possible, storehouses will be supplied with stock number S1-1131 Penicillin, calcium, 100,000 Oxford units per ampule. This material has a potency period of approximately 12 months, but is identical with penicillin sodium, as to storage and use. It should be stored at a temperature minus 15 degrees centigrade.

Reports of expired penicillin are routinely answered "expired penicillin may be used by local application or intramuscular injection allowing for decreased potency." The amount of decrease in potency cannot be accurately stated as it may vary somewhat from lot to lot and is influenced by inadequate refrigeration; however, there appears to be a progressive decrease after expiration date. Samples which had expired approximately one month prior to test have indicated a decrease of 20 per cent in potency. (K.C.M.)

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Notes on the Use of Diagnostic Antisera in Clinical Laboratory Practice: It is now known that many bacteria formerly regarded as entities are in reality aggregates of closely related races. The simple statement that an organism is a pneumococcus must be qualified by stating which of the seventy odd types of pneumococcus is meant, since these all differ one from the other in chemical makeup and even in pathogenicity. The same applies to the meningococci, enteric pathogens and others. Knowledge that these subgroups exist has changed many of the accepted practices of the clinical bacteriologist and has brought into prominence the use of serological methods, particularly the use of specific diagnostic antisera.

Such antisera are prepared by the injection of animals with the antigenic fractions upon which the given classification is based. They are employed as antibodies in testing by a variety of technics: agglutination, precipitation, Quellung formation, and complement fixation. The specificity of such sera varies widely, some being for species or genera, others for isolated antigenic substances common to a single race. The use of many of these serologic adjuncts to biochemical methods is not practical except for highly specialized laboratory activities and several general rules can be suggested to govern their use:

1. The training of the person entrusted with the use of diagnostic sera is of extreme importance. Unless he be experienced in the intricacies of serologic methods and the interpretation of findings there is little use in expending time and effort on such refinements.

2. The practical need for such procedures, as appraised in its relation to the actual treatment of the patient, should be considered. Classification of organisms by serologic methods is often of extreme value to the epidemiologist but, at the present time, may exert little influence upon the actual individual therapy. This would suggest that laboratories connected with smaller activities in most instances should not divert time and material from their more vital functions.

3. The scope of serologic methods employed by any given laboratory should be influenced to some extent by the ease with which communication can be had with some nearby service laboratory equipped to carry out these more complicated procedures. The facilities of the Naval Medical School, where desired, are available for this work.

4. Each laboratory will have its own individual problems peculiar to the type of operations, geographic location, and special medical implications of the forces it serves.

The Streptococci: Beta hemolytic streptococci have been classified by a variety of serologic technics. The most satisfactory includes first a breaking down into groups and then the typing of those groups of greatest importance in human disease. Groupings are fairly simply done and should be performed by most laboratory activities. By this procedure group A organisms, which include the majority of human pathogens, can be segregated and sent to the Streptococcus Typing Laboratory, Naval Medical School, Bethesda 14, Maryland, for final identification. Streptococcus grouping sera are available at the Naval Medical Supply Depot, Brooklyn, New York.

The Pneumococci: The importance of pneumococcus typing, which has paralleled the use of type specific therapeutic serum, has greatly diminished recently owing to the successful use of the antibacterial drugs. There are,

however, instances when a typing can be of considerable value and naval laboratories should be equipped to perform this test. The Quellung reaction is the most satisfactory, and typing sera for use in this method are included in the supplementary Supply Table.

The Meningococci: Although there is no correlation between type and response to chemotherapy, it is of importance that more information be obtained regarding the biology of this group. The test in common use is one of agglutination, and sera for it can be obtained through the Medical Supply Depot, Brooklyn, New York.

The Influenza Bacilli (Hemophilus influenzae): Smooth strains of the influenza bacillus can be typed by the same method as that used with the pneumococci. However, this organism at present is of most interest in the field of pediatrics where influenza bacillus meningitis is a problem. The rarity with which it is encountered at present in military personnel would seem to preclude the general distribution of typing sera to most clinical laboratories, but they should be available by open purchase to those activities where there is a demand.

The Enteric Group: (a) Typing of the Salmonellae is beyond the scope of the ordinary clinical laboratory owing to the antigenic complexity of the entire group. Reliance should be placed upon the Naval Medical School Enteric Pathogen Laboratory at Bethesda to which those organisms possessing the biochemical properties of the genus should be submitted for complete analysis.

(b) The antigenic structure of the Shigellae is complex but not beyond the scope of the clinical laboratory. Much information is needed concerning the world-wide distribution and prevalence of the dysentery group, and it is urged that all laboratories avail themselves of the eighteen types of diagnostic sera stocked by the Supply Depot. The Enteric Pathogen Laboratory is anxious to obtain cultures of all strains of Shigellae isolated anywhere and such should be forwarded when possible, even when typings have already been done.

(c) Monovalent antityphoid serum is probably of little real value in a general clinical laboratory.

Miscellaneous: (a) Antisera are of importance in the separation of a number of the viruses. For example, the sera of patients convalescent from psittacosis or lymphocytic choriomeningitis exhibit complement fixing properties when tissue containing the specific virus or a suspension of the specific virus of one or the other disease is employed as antigen. The technic is beyond the scope of the usual clinical laboratory at this time.

(b) Several other groups of bacteria are separated and identified through the use of diagnostic antisera but because of technical difficulties, lack of commercially available materials, or unreliability of interpretation, are not

recommended. The Brucella, for instance, can be divided into melitensis and abortus-suis classes through the use of absorbed sera but such a separation is rarely needed. Recent results suggest that the various rickettsiae can also be subdivided by serologic means, but again, this is not considered to be a problem for the average clinical laboratory. (P.W.W.)

* * * * * *

Duties of V-12 Unit Medical Officers Relative to Contract Messes: Information received in the Bureau indicates that there is some confusion relative to the duties of medical officers in V-12 Units pertaining to inspection of rations and messes. Attention is invited to Section 13 of the Navy V-12 Bulletin No. 200, "Manual for the Operation of Navy V-12 Units." The medical officers are charged with specific responsibilities under the direction of the commanding officer among which are (1301-j): "Hold health and sanitary inspections, including inspections of messing and berthing spaces." (1301-k) "Inspect all fresh provisions and daily rations and the methods and facilities used in the storage, preparation and serving of foods." The Bureau is of the opinion that such inspections are of even greater importance in contract messes than in official naval messes. It is felt that all food handlers in contract messes should have physical examinations before employment as such, in compliance with the local or state regulations. Insofar as the Navy is concerned, blood Kahn tests are not deemed essential unless required by local or state ordinances. (T.J.C.)

* * * * * *

Effect of Yeast and Yeast Products on Complement of Guinea-Pig Serum: Guinea-pig serum is of no value for use in complement fixation tests during the greater part of the year in Calcutta owing to climatic conditions. The heat causes it to lose its titer and become "cholesterol shy." The authors have found that adding marmite, yeast tablets or vegemite to the diet of the guinea pig will correct these defects.

A group of 100 animals were given four teaspoonfuls of marmite daily for the first few weeks, then two teaspoonfuls daily. After adding marmite to the food both the defects disappeared within two weeks and did not reappear for five years.

Experiments were made also on another group of 100 animals using yeast tablets and vegemite. Nearly normal complement was obtained in some of these animals. (Greval et al., Indian M. Gaz., Calcutta, Jan. '44, abstracted in Ven. Dis. Inform., July '44.)

* * * * * *

The Use of Soap as a Dentifrice: A survey of 48 members of the officer staff and enlisted personnel of the Naval Medical Research Institute was carried

out to determine the feasibility of recommending soap for brushing the teeth in situations where a proprietary dentifrice is unobtainable.

Each person was given a small piece of unscented white soap of the "floating" variety. Instructions were given to substitute this soap for his regular dentifrice, and to use it twice daily over a period of two weeks. At the end of this period a questionnaire form was submitted to each subject.

The form of the questionnaire and answers are reproduced below.

1. Do you find the taste of soap objectionable after two daily brushings over a period of two weeks? Yes - 7, No - 41.
2. From your experience, does the cleansing quality of soap compare with that of a commercial paste, powder or liquid? Better - 7, Same - 35, Inadequate - 6.
3. Does continued use of soap produce soreness of your gums or mouth? Yes - 3, No - 45.
4. Do you find the use of soap convenient as compared with a paste, powder or liquid? More convenient - 18, Same - 21, Not as convenient - 9.
5. Would you consider it practical to use a small cake of soap for brushing your teeth in the field? Yes - 44, No - 4.
6. Should an emergency arise, would you use soap if commercial paste, powder or liquid were unobtainable? Yes - 46, No - 2.

On the whole the taste of soap was found to be unobjectionable. The problem of taste was only of minor importance. Most personnel expressed a preference for soap without any kind of flavoring agent. The majority of the personnel were of the opinion that the cleansing quality of soap compared well with that of their favorite dentifrice, while four desired a mild abrasive in their dentifrice.

Two subjects stated that they would much prefer to use salt (sodium chloride) or baking soda (sodium bicarbonate) rather than use soap for brushing their teeth. Three subjects attributed a slight soreness of their gums and mouth to the soap.

The question as to the amount of soap necessary for brushing the teeth, and the practical means of stowage in the field should present no serious problem to the personnel. From the survey it was found that a small piece of soap, used two to three times daily would last several weeks. Guest size (the cakes usually dispensed at hotels), is roughly the proper amount, and pieces of equivalent size may also be cut from an ordinary bar of soap. For stowage, small plastic cosmetic containers, ointment jars, or improvised envelopes made of waterproof cellophane are suggested.

Analyses of Various Dentifrices: The amount of "free alkali" and the hydrogen ion concentration were determined with respect to the three brands of soap used in this survey and five proprietary dentifrices known to contain soap. Only two of the five dentifrices contained free alkali. The percentage of free alkali in these two (0.05 to 0.08 per cent) was the same as or greater than that of the soaps used (0.02 and 0.05 per cent). The range of hydrogen ion concentration in the dentifrices was from pH 9.4 to 10.4. All the soaps were approximately at the upper end of this range (pH 10.4).

Conclusions: (1) The use of these soaps for brushing the teeth and gums in situations where proprietary dentifrices are unobtainable should aid materially in promoting better oral hygiene among our personnel. (2) Irritation of the gums and mouth is no more likely to occur from the use of these soaps than from the use of some of the proprietary dentifrices containing soap. (J.S.R.)

* * * * * *

Converting Cartridge Boxes into Fly Traps: Fly traps are an effective supplementary means of controlling fly-borne diseases. Fly traps may be constructed in many ways from various discarded materials. An ingenious method of converting a cartridge box into a fly trap has recently been developed at the Naval Medical Research Institute. It is done by replacing the top with a screen and a small door, and the bottom with a screen.

The tools required are a saw and hammer, and the only materials needed are wire screening (13" x 26") and a dozen small nails or tacks. The wood, nails, and wing nuts from the cartridge box are used again in making the fly trap.

Directions for Converting a 30-Caliber Cartridge Box into a Fly Trap:

1. (a) Unscrew and save all the wing nuts from the lid.
   (b) Remove, but do not throw away lid (Fig. 1).

2. Knock out the bottom carefully (remove and save the nails), saw the wood with the grain into the following strips:

four (5-1/2" x 1")
two (12" x 1")
one (9-1/4" x 2")
one (9-1/2" x 5")

3. (a) Turn box upside down.
   (b) Puncture 6 one-quarter inch holes along the center of the large screen (16-1/4" x 13") and place it in the box so that it forms a trough, V-shape (Fig. 2).

Method of Converting 30 Caliber Cartridge Box into Fly Trap.

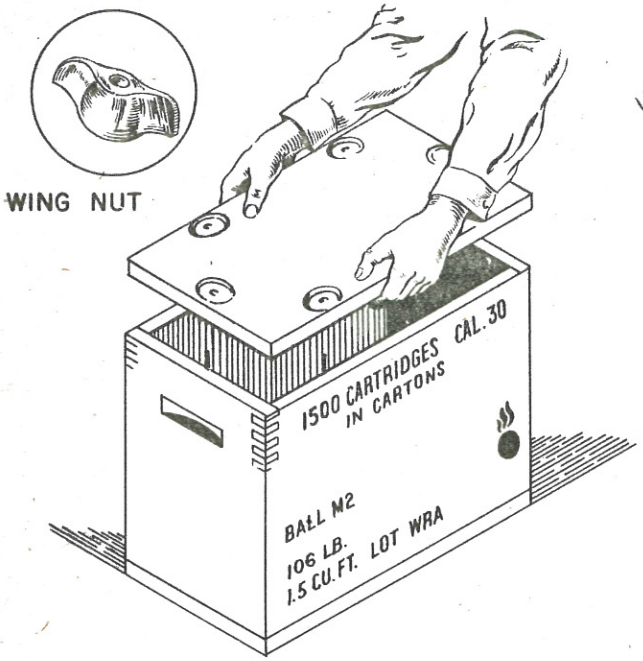

FIG. - 1

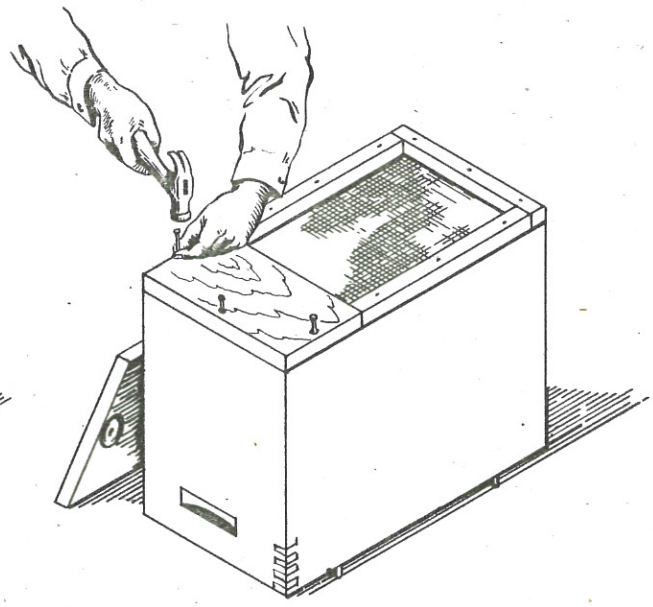

FIG. - 3

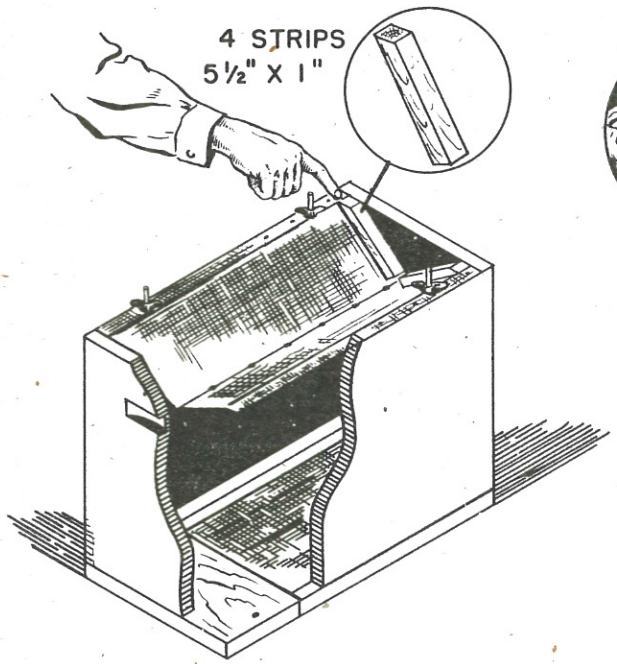

FIG. - 2

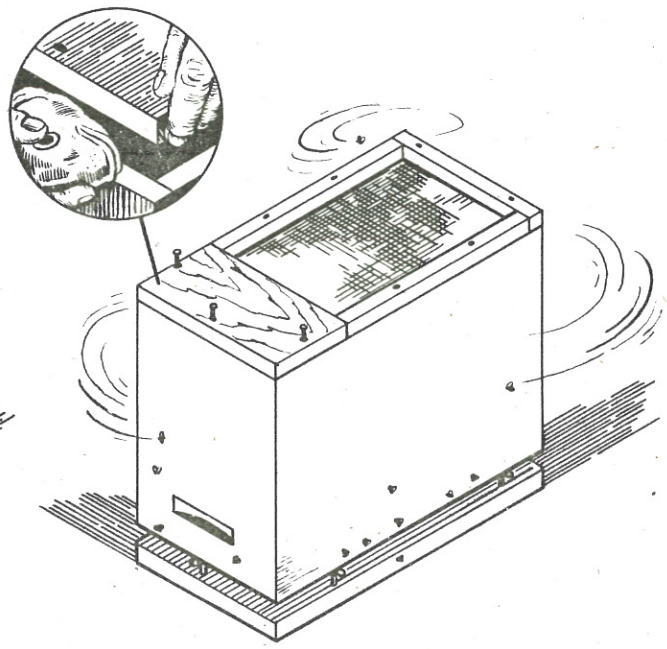

FIG. - 4

DDF NMRI - 44'

(c) Reinforce the ends of the screen with the strips of wood (5-1/2" x 1") and nail two strips to each side of the box.

(d) Now replace each wing nut and screw down firmly (Fig. 2).

4. Once again turn the box over, and nail the screen (13" x 9-3/4") tightly drawn with the aid of the remaining strip of wood. Then place the small door (9-1/2" x 5") in position, driving three nails only half way (to facilitate removal) (Fig. 3).

5. Use the old lid (upside down) as a platform on which to place the converted fly trap. The wing nuts act as feet for the trap and leave an opening of about 1" for flies to enter (Fig. 4).

6. Place bait (preferably fish heads or any decaying material) in the trap through the door by removing the end nail and replacing it to fasten the door (Fig. 4).

7. Re-bait the trap every few days. Flies can be killed by exposing the trap to sunlight or by using boiling water.

* * * * * *

Requisitions for Ear Wardens: Several requests for Ear Wardens have been received by the Bureau of Medicine and Surgery. Attention is called to the fact that Ear Wardens (see Form Letter in this issue) are not an item of issue by BuMed but are on the Allowance List of BuShips and BuAer. Procurement should be initiated by the Supply Officer and not by the Medical Officer. (E.W.B.)

* * * * * *

Government Insurance: A Revised Bulletin of Information and Instructions Concerning (1) National Service Life Insurance, (2) U. S. Government Life Insurance and (3) Premium-Paying Insurance Allotments has been published in the Navy Department Semimonthly Bulletin of June 30, 1944.

The Form Letter of which the Bulletin is an enclosure states that the latter "is promulgated because of changes in procedure made necessary by recent legislation and regulations affecting insurance and premium-paying allotments, and to consolidate instructions."

The Form Letter emphasizes the fact that it is "essential that prior to being released from active duty each person be advised of the privilege of retaining Government insurance in force, the benefits to be derived therefrom and the rights and conditions of conversion of National Service Life Insurance to permanent plans." The complete 46-page bulletin reproduces all necessary blank forms.

Stock Item No. 4-666 and 4-667, Lamp Bulb, Nitrogen (220 and 115 volts) (for Leitz Microscope Lamp) Deletion from Supply Catalog: These lamp bulbs were furnished for the old Leitz Microscope Lamp which has been discontinued for some time. Most activities using the Leitz Lamp obtain standard stock bulbs from their local Maintenance Department. On recent contract the Supply Department and Lamp Bulb Manufacturers were unable to furnish the type of bulb originally used and stocked for the Leitz Lamp. The A-21 standard type bulb available at the local maintenance departments of all activities was recommended as an adequate substitute (K.C.M.)

* * * * * *

ALNAV #132: Section 104 of the Serviceman's Readjustment Act of 1944, Public Law 346 is quoted for compliance:

"No person shall be discharged or released from active duty in the armed forces until his certificate of discharge or release from active duty and final pay, or a substantial portion thereof, are ready for delivery to him or to his next of kin or legal representative; and no person shall be discharged or released from active service on account of disability until and unless he has executed a claim for compensation, pension, or hospitalization, to be filled with the Veterans' Administration or has signed a statement that he has had explained to him the right to file such claim: provided, that this section shall not preclude immediate transfer to a veterans' facility for necessary hospital care, nor preclude the discharge of any person who refuses to sign such claim or statement: and provided further, that refusal or failure to file a claim shall be without prejudice to any right the veteran may subsequently assert. Any person entitled to a prosthetic appliance shall be entitled, in addition, to necessary fitting and training, including institutional training, in the use of such appliance, whether in a service or a Veterans' Administration Hospital, or by out-patient treatment, including such service under contract."

* * * * * *

Public Health Foreign Reports:

Disease	Place	Date	Number of Cases
Smallpox	Algeria	May 1-10, '44	72
		May 11-20, '44	37
		May 21-31, '44	32
	Cameroon (Fr.)	Apr. 1-20, '44	143
	Egypt	May 20-27, '44	428 (24 fatal)
	Great Britain		
	England	May 6-13, '44	1
	Greece	January '44	106
		Feb. 11-29, '44	103

Public Health Foreign Reports (Cont.):

Disease	Place	Date	Number of Cases
Smallpox	India - Bombay	Apr. 22-29, '44	78 (25 fatal)
		Apr. 30-May 6, '44	74 (27 fatal)
		May 6-13, '44	49 (27 fatal)
	Calcutta	May 6-13, '44	267 (fatal)
		May 13-20, '44	258 (fatal)
		June 3-10, '44	132 (122 fatal)
	Nigeria	Apr. 22-29, '44	124 (21 fatal)
		Apr. 29-May 6, '44	174 (46 fatal)
		May 20-27, '44	165 (20 fatal)
	Peru	March '44	14
	Turkey	March '44	851
		April '44	295
	Venezuela	May '44	66
Typhus Fever	Algeria	May 1-10, '44	92
		May 11-20, '44	70
		May 21-31, '44	72
	Belgium	Apr. 29-May 6, '44	1
	Bulgaria	Mar. 11-18, '44	73
	Chile	Mar. 26-Apr. 22, '44	34 (2 fatal)
	China, Kunming	May 20-27, '44	10 (1 fatal)
	Greece	January '44	28
		February '44	20
	Guatemala	April '44	399 (94 fatal)
	Hungary	May 6-13, '44	158
		May 13-20, '44	153
	Iran	Apr. 1-May 26, '44	2,562 (192 fatal)
	Iraq	Apr. 15-22, '44	27 (1 fatal)
		Apr. 22-29, '44	26 (4 fatal)
	Irish Free State, Roscommon County Castlerea	May 13-20, '44	1
		May 20-27, '44	1
		May 27-June 3, '44	1
		June 3-June 10, '44	1
	Morocco (Fr.)	April '44	409
	Palestine	April '44	76 (6 fatal)
	Peru	March '44	70
	Slovakia	May 13-20, '44	19
	Tunisia	Apr. 11-20, '44	30
		Apr. 21-30, '44	37

(Pub. Health Reps., June 16, 23, and July 7, '44.)

To: All Ships and Stations. BUMED-X-AMM-II
A11/P3-1(112)

Subj: Prevention of Ear Damage - Directions for the Use of the V-51 (R) NDRC Ear Warden. 17 Jun 1944

Ref: (a) Form Ltr 29, A11/P3-1(112), of 26 Feb 1942; N.D. Bul. Cum. Ed. 1943, p. 422.

1. INTRODUCTION

a. The importance of ear protection against continuous high noise levels and gun blast was discussed in reference (a). The subject ear defender, officially designated as "ear warden", was developed for the armed services by the National Defense Research Committee and has been adopted by the naval service. It is not an item of issue by the Bureau of Medicine and Surgery, but is on the Allowance List of the Bureau of Ships and the Bureau of Aeronautics.

2. PURPOSE

a. The ear warden provides a convenient and comfortable device for occluding the auditory canal. When correctly inserted, it minimizes noise and protects the wearer against extreme acoustic shock.

3. APPLICATIONS

a. In situations where a high noise level is continuously maintained, as in Diesel and motor-torpedo-boat engine rooms, the routine use of an ear warden lessens the hazard of temporary or permanent hearing impairment. It furnishes protection against the consequences of continued exposure to gun blast. Furthermore, the use of this ear warden does not seriously impair the reception of commands when personnel are exposed to loud noises.

4. FITTING

a. The fitting of ear wardens shall be conducted under the supervision of a medical officer. The auditory canal shall be examined and any excess of ear wax removed. During this examination, the proper size of ear warden can usually be determined by inspection of the opening of the canal.

b. Available sizes: There are three sizes, i.e., small, medium, and large, for which the distribution ratio is 1:2:1. Selection from the standard sizes should result in a comfortable fit and a good seal. An occasional individual will require a plug for one ear larger or smaller than is required for the other ear. Men for whom the smallest warden is too large for a comfortable fit, and men for whom the largest size does not give an adequate seal, can obtain considerable auditory protection by plugging the ears with cotton.

c. If the seal in both ears is good, the wearer will notice a change in the loudness of the sounds around him, and especially a change in the quality of his own voice. A plug that is loosened by yawning or chewing is too small, and one giving rise to greater discomfort than a sense of fullness is too large. It is advisable to explain to personnel that there is no possibility of touching the ear drum with an ear warden of the proper size.

d. Insertion: While the ear warden can be correctly inserted with the fingers, this is greatly facilitated by means of a special applicator. For this reason, subject ear warden is furnished in a plastic container, the central portion of which is shaped to serve as an applicator. Four prongs, at either end of the device, are so proportioned as to accommodate, interchangeably, all sizes of ear wardens. From these prongs the warden is readily pushed into a normal ear canal. The ear warden should be inserted to the limit permitted by the safety tab, which should lie flat against the lobe of the ear. The removal tab should point toward the back of the wearer's ear for maximum protection. The ear wardens should be firmly replaced upon the applicators after use. In tortuous canals, insertion is facilitated by grasping between thumb and forefinger the top of the external ear which is then pulled upward and/or backward in order to straighten the external portion of the canal.

5. CONTRAINDICATIONS

a. Ear wardens should not be used (1) when examination of the auditory canal reveals the presence of a skin eruption, furuncles; fungous infection or inflammation, and (2) when, in a quiet location, it is imperative to hear weak sounds, such as whispered commands or the first faint warning of enemy activity.

6. CARE IN CLEANING

a. Ear wardens, and the ears receiving them, should be kept scrupulously clean. The neoprene compound from which they are manufactured is nontoxic and markedly resistant to sea water and the action of ear wax. Ear wax, if visible, should be carefully wiped from the wardens after each period of use. Thorough cleansing should be carried out from time to time, with soap and water. Under no circumstances shall ear wardens be transferred from the custody of one person to another or be worn by another person unless disinfected. The following disinfectants are suitable for this purpose: BuMed Stock Nos. 1-851 or S1-4790; also, BuShips Stock No. 51D394-78. Neither alcohol nor phenol should be employed for this purpose. When the mushroom-shaped flange of the warden has been badly deformed through use or abuse, it should be replaced by a new plug. --BuMed. Ross T McIntire.

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To: All Ships and Stations. BUMED-Ca-GJS P6-3(054)

Subj: Remains of Dead - Report of Disposition and Expenditures in Connection Therewith. 17 Jun 1944

Refs: (a) Par 2902, Manual of the Medical Department.
(b) Bureau Circ Ltr F, Remains, Report of Disposition and Instructions, Appendix D, Manual of the Medical Department.

1. The form of report of disposition of remains as outlined in reference (b) has been revised. Reference (b) is accordingly canceled and, effective immediately, the report required by reference (a) shall be submitted in duplicate as follows:

FORM OF REPORT

To: BuMed.
Subj: Remains of Dead - Report of Disposition and Expenditures in Connection Therewith.

1. U. S. ..... Date .....
(Official name of activity preparing report)
File No. .....
(Officer)
2. Name of Deceased ..... Ser. No. .....
(Name in full, surname first) (Rank or rating) (Enlisted)
3. Station to which attached on date of death .....
(If enroute to new station, indicate such station)
4. Place of death ..... Date of death .....
(actual date)
(If death occurred on naval reservation, indicate official name. If death occurred outside of naval reservation, indicate name of city, county, State or foreign country. If on leave, so indicate. If aboard ship, indicate name and port.)
5. Disposition:
(a) Local interment - Lot No. ..... Grave No. ..... Cemetery.....
(b) To home, addressed to .....
(Name, address, and relationship of person to whom remains were shipped)
(c) To National Cemetery for interment .....
(Indicate name and locality of such cemetery)
(d) To other naval activity, which is furnished copy of this report .....
.....
(Name of activity to which remains were delivered or shipped)
(e) Shipped via .....
(Indicate (1) name of initial railroad (New York Central and connecting lines), (2) name of steamship (SS PRESIDENT PIERCE), (3) name of Army or Navy vessel)
(f) Remains not recovered .....
(g) Name and relation of escort.....

6. Remarks: .....
Indicate any clarifying information necessary. The Bureau must have on file complete information relative to each activity handling the remains of each deceased person and information relative to all applicable expenditures chargeable to the appropriation, Medical Department, Navy.

In those instances where the undertaker's bill is forwarded to the Bureau of Medicine and Surgery for settlement, this information should be indicated under this paragraph; i.e., all bills in conjunction with the preparation and encasement of the above-named deceased have been forwarded to the Bureau of Medicine and Surgery for payment.

7. Expenditures chargeable to the appropriation, Medical Department, Navy F.Y. ..... to be reported on NavMed Form B for F.Y. ....., period ended.....
(a) Burial Expense, 07-50 (include all contract services of undertaker except cost of casket. Cremation costs should be indicated separately.)
Public Voucher - D.O.V. No. ..... BuVouNo. ..... $ .....
(b) Caskets and Mortuary Supplies, 08-52 (include cost of casket furnished by undertaker. Do not include caskets received from a medical supply depot or other Medical Department activity.)
Public Voucher - D.O.V. No. ..... BuVouNo. ..... $ .....
Sub Total (P.V. paid locally)
(c) Clothing and Small Stores, 08-52.
Expenditure Invoice No .....
(d) Transportation, 03-51.
Cash advanced to escort covering transfer of remains only from one railroad station, or pier, to another.
Public Voucher - D.O.V. No ..... BuVou No.....
(e) Estimated Transportation (common carrier only), 03-51.
Transportation Request No ..... $ .....
or
Express Bill of Lading No ..... $ ..... $ .....
Grand total chargeable to appropriation
Medical Department (Allotment No .....) $ .....

8. Other expenditures not chargeable to appropriation, Medical Department, Navy.
(a) Navy Standard Casket $.....
(b) Funeral Flag $.....
(c) Estimated Transportation Costs to be charged to the appropriation, General Expenses, U. S. Marine Corps, F. Y. ..... $.....
(d) Others: Reverse Lend-Lease, etc. $.....

2. The above form will be prepared locally as required. Appropriate change in the Manual of the Medical Department will be made as soon as practicable.

3. This report shall be classified as may be required by current security instructions. --BuMed. Ross T McIntire.

To: All Ships and Stations BUMED-C-LET
HJ/EF (032)

Subj: Assignment of Red Cross Personnel With Medical Department in Overseas Service. 12 Jul 1944

Encl: (A) Outline of Red Cross Aid in Evacuation of Casualties.

1. The Chief of Naval Operations has approved the assignment and utilization of Red Cross personnel with the Medical Department at naval base hospitals and fleet hospitals, in hospital ships, and in the evacuation of casualties in ambulance transports and other transports designated for this purpose.

2. Medical officers in command of naval base hospitals and of fleet hospitals now in commission overseas, and the commanding officers of hospital ships operating overseas, shall request assignment of Red Cross personnel (male or female) through official channels from the Red Cross delegate responsible for Red Cross services in the particular theater in which located or operating. The services to be rendered to patients are those outlined in article 1474, Navy Regulations, 1920 (NavDeptBul., Vol. IV, No. 2, 31 Jan. 1944). Base hospitals and fleet hospitals being organized in continental United States, and hospital ships outfitting, shall make request for Red Cross personnel to BuMed.

3. Commanding officers of ambulance transports or other transports designated for the evacuation of casualties will be guided by enclosure in requesting Red Cross personnel. Only male personnel will be assigned. Request should be directed through official channels to the Red Cross delegate having jurisdiction of the area through such Red Cross agency as may be operating in the port from which the casualties are to be evacuated.

4. The assignment of female Red Cross personnel to naval base hospitals and fleet hospitals to which members of the Navy Nurse Corps are attached, and to hospital ships, has been specifically approved.

5. The Red Cross will provide uniforms, pay and allowances for quarters and subsistence for personnel assigned. Aboard hospital ships and at naval base and fleet hospitals Red Cross personnel will be charged for subsistence on the same basis as Navy nurses. In transports Red Cross personnel will be charged for subsistence as required to reimburse the mess to which attached. No charge for quarters is to be made.

6. For base and fleet hospitals under 1,000 bed capacity, the Red Cross complement is:

1 Assistant Field Director (Social Worker)
1 Recreation Worker
1 Secretary

For hospitals of 1,000 beds or over:

1 Assistant Field Director (Social Worker)
1 Hospital Worker (Staff Aide)
2 Recreation Workers
1 Secretary

For hospital ships:

1 Assistant Field Director (Social Worker)
1 Recreation Worker

--BuMed. Ross T McIntire.

Enclosure (A)

OUTLINE OF RED CROSS AID IN EVACUATION OF CASUALTIES:

1. The American Red Cross is prepared to provide continuous service to the sick and wounded men returning to the United States from overseas areas.

2. As casualties are evacuated in ships under control of the Navy, which perform transport duty on the outbound voyage and serve as ambulance ships on the return voyage, the Red Cross would assign personnel to each such ship on its return voyage. When patients number between 100 and 500, one worker would be assigned. For more than 500 patients an additional worker would be provided. This general ratio should not be construed as preventing the assignment of a Red Cross worker when the patient group is less than 100, if the commanding officer of the activity should consider that the service is needed. Male personnel only would be so assigned. Subject to the orders of the naval authority in command at port of embarkation, the Red Cross personnel for transport duty would report to the commanding officer of the vessel for assignment to work under the direction of the medical officer.

3. Supplies suited to the workers' use in service to patients will be provided by the Red Cross. In those instances where the cognizant medical officer considers the number of casualties to be transported as too small to warrant assignment of a Red Cross worker, the Red Cross field director at the port will furnish the medical officer of the vessel at his request sufficient comfort and recreation supplies to meet the needs of the patients en route. These supplies will not duplicate those furnished by the Navy.

4. The services to be rendered by Red Cross workers on ambulance transports and transports being used for evacuation of casualties are:

(a) To provide toilet articles, cigarettes, and other comfort items to patients in need of them.

(b) To provide means whereby patients without funds may make necessary expenditures for supplies or services en route, which cannot be furnished in kind by the worker.

(c) To interpret to those patients who are apprehensive about their future the governmental benefits available to men discharged due to disability.

(d) To furnish recreational supplies and assist in a medically approved recreational program for patients.

(e) To consider with patients those personal and family problems which require attention and provide for immediate and continued Red Cross service upon arrival in port.

SUPPLIES

(a) Convalescent kit bags.

The American Red Cross will place aboard ship a sufficient number of cartons packed with convalescent kit bags containing comfort articles for each patient. Each carton will contain 25 convalescent kits. Each carton is estimated to weigh 50 pounds and will occupy 3 cubic feet of space. As many of these kits will be taken aboard with the worker as are required to meet the needs of the number of sick and wounded aboard ship.

(b) A recreation kit has been set up containing approximately 40 specific items of recreational equipment to meet the needs of 50 patients. The kit containing these items weighs approximately 90 pounds and occupies 6 cubic feet of space. The number of kits required will be determined by the number of sick and wounded aboard ship in units of 50 each.

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THE JOINT CHIEFS OF STAFF
WASHINGTON, D. C.

JSC/B22
Serial 7109

Restricted
29 Jul 1944

MEMORANDUM FOR: Director, Bureau of Public Relations
Director, Office of Public Relations, USN
Colonel H. M. O'Connor, Inter-Service Security Board
Surgeon General, Army
Chief of the Bureau of Medicine and Surgery, Navy
Office of Censorship
Office of War Information

SUBJECT: Publicity Policy on Malaria and Malarial Control

1. The following policy, approved by the Joint Chiefs of Staff and concurred in by Inter-Services Security Board, will become effective at 1800 Z on 30 July 1944:

a. Information regarding malaria and malaria control will be divided into the following classes:

(1) Classified

(a) Full chemical names, formulae, methods of manufacture and propagation of new chemicals and biological agents for the treatment, prophylaxis or field control of malaria which are developed after the date of approval of this policy or which are now developed and are presumed to be unknown to the enemy.

(b) Statistical information concerning the incidence of malaria in the armed forces in any particular combat area and the casualties or the casualty rates resulting therefrom.

(c) Information involving designation of theaters of operation by names and locations.

(d) Information which reveals the scope and extent of our research in this field or the progress made in any specific phase of such research.

(e) Information which reveals the full extent of anti-malarial measures which are being taken in any particular combat area.

(f) Information concerning development of malaria control and survey units.

(2) Unclassified: Information about malaria and malaria control which has already been published and is a matter of common knowledge.

(a) Clinical description of malaria.

(b) Material on the biology of malaria parasites and vectors.

(c) Names of existing chemicals or biological agents used for the treatment, prophylaxis or field control of malaria which are matters of common knowledge.

(d) General description of methods used for treatment, prophylaxis or field control of malaria which are matters of common knowledge.

b. The joint policy governing the release of publicity of malaria and malaria control will be confined to the release of only the unclassified information above.

c. Within the limits of the policy stated in paragraph b. above and under the control of Joint Security Control as specified in J.C.S. 630/6, the Surgeon General of the Army and the Surgeon General of the Navy will be authorized to recommend for publication articles dealing with malaria, subject to clearance respectively with the War Department Bureau of Public Relations or with the Office of Public Relations, Navy Department.

2. The directors of the Bureau of Public Relations, U.S.A. and the Office of Public Relations, U.S.N., will notify all interested agencies.

--For Joint Security Control: George W. Cutting, Colonel, M. I.

To: MedOfCom NavHosps and SMO Major Shore Stations in U. S.

BUMED-R3-HMS
P3-5(061-43)

Subj: Boards of Medical Survey, instructions for.

11 Jul 1944

Ref: (a) Paragraph 3423(k)(4), Manual of the Medical Department.
(b) BuMed Letter P3-5(061) dated June 8, 1943.
(c) BuMed Letter P3-5(061) dated October 26, 1943.

1. Section 105 of Public Law No. 346, 78th Congress, approved June 22, 1944 is quoted for your information:

> "Sec. 105: No person in the armed forces shall be required by any official thereof to sign a statement of any nature relating to the origin, incurrence, or aggravation of any disease or injury he may have, or any other statement against his own interest, and any such statement against his own interest signed at any time, shall be null and void and of no force and effect."

2. In view of the above legislation, the preparation and submission of the statements required by references (a), (b), and (c) shall be discontinued upon the receipt of this letter.

3. Hereafter, when a Board of Medical Survey finds that an individual has a disability which was not incurred in the line of duty, the senior member of the Board shall inform him verbally of the Board's findings regarding the nature and origin of the disability and whether or not it is considered to have been aggravated by service. The Board shall then afford him an opportunity to submit a statement in rebuttal. The report of Medical Survey shall contain the following statement: "The patient has been informed of the Board's findings and does (does not) desire to submit a statement in rebuttal." If a patient submits a statement in rebuttal, it shall accompany the report of Medical Survey to the Bureau.

4. The provisions of the preceding paragraph shall not apply in case the individual is considered to be mentally incompetent or in case the possession of information concerning the nature of his disability is considered by the Board likely to be detrimental to his health.

--BuMed. Ross T McIntire.